PRINTED: 7/27/2023 FORM APPROVED 2567-L

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	395164				00.	06/16/2023	
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			STREET ADDRESS, P O BOX 928 S MARS, PA 16	500 WITTE	MP CODE: NBERG WAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0000 F 0656 SS=E	Based on a Medicare/N Survey, Civil Rights Continuous Licensure Survey complex as determined that Stocenter, was not in composed of 42 CFR part 483, Stocenter Care Facilia Commonwealth of Pen Licensure Regulations of the survey process.	ompliance Survey, a pleted on June 16, 20. John Specialty Carupliance with the requispart B, Requirementies and the 28 PA Consylvania Long Terrelated to the health	and State 023, it e uirements nts for Code, m Care portion	F 0656	TITI E-	(Y6) DATE:	
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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,		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395164			<u></u>	06/16/2023	
ST. JOHN	VIDER OR SUPPLIER: SPECIALTY CARE CTR E NUMBER: 970802		P O BOX 928 MARS, PA 16	500 WITTE	IP CODE: NBERG WAY		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEI ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0656	Continued from page 1		F 0656				
SS=E	483.21(b)(1)(3) Develop/Im Plan §483.21(b) Comprehensive §483.21(b)(1) The facility in comprehensive person-center consistent with the resident and §483.10(c)(3), that inclutimeframes to meet a resider and psychosocial needs that comprehensive assessment. must describe the following (i) The services that are to be maintain the resident's higher and psychosocial well-being §483.25 or §483.40; and (ii) Any services that would §483.24, §483.25 or §483.44 resident's exercise of rights right to refuse treatment und (iii) Any specialized services services the nursing facility PASARR recommendations findings of the PASARR, it resident's medical record. (iv)In consultation with the representative(s)-(A) The resident's goals for outcomes.	Care Plans nust develop and implenered care plan for each regights set forth at §483.1 ades measurable objectivates medical, nursing, an are identified in the The comprehensive care furnished to attain or est practicable physical, as required under §483 otherwise be required under §483.10, including ler §483.10(c)(6). Is or specialized rehability will provide as a result of the funder in the facility disagrees where th	ment a esident, 10(c)(2) ves and d mental e plan mental, 224, ander ue to the g the tative of with the ale in the		1. The care plan for reside was updated to reflect their diagnosis. The care plan for R35 was updated to reflect or use. The care plan for reside was updated to reflect oxyge and usage. Resident R246 discharged on 6/29/2023. 2. Nurses notes will be me each business day during clir report beginning 6/28/23 and continue ongoing. Any resid with new diagnoses or treatm will be discussed and care planewise to determine if add interventions are needed. 3. Audit of current resider be completed by 7/21/2023 to identify those using oxygen ensure careplans reflect diagrand physician orders. 4. New admission care plabe audited by day 5 to ensure diagnoses and physician orders. 5. DON or designee will enamage importance of documenting importanc	resident exygen nt R148 en care conitored nical d will ents nents lans litional nts will to and to enosis ans will e ers are educate ers on the	Completion Date: 07/28/2023 Status: APPROVED Date: 07/10/2023
	(B) The resident's preference	e and potential for future	e		diagnoses and orders and up		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE					(X3) DATE SURVE COMPLETED:	ΞY	
		395164		B. WING:		06/16/2023	
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE STATE LICENSE NUMBER: 970802	CTR		STREET ADDRESS, P O BOX 928 MARS, PA 16	500 WITTE	IP CODE: NBERG WAY		
* *	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFI MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHORES FROM THE ACTION THE ACTION THE ACTION THE ACTION TO THE ACTION OF THE	OULD BE	(X5) COMPLETE DATE
desire to return to the referrals to local consentities, for this purp (C) Discharge plans appropriate, in accordin paragraph (c) of the \$483.21(b)(3) The second facility, as outlined to (iii) Be culturally-consented.	must de comm tact age ose. in the c dance v his sect ervices by the c mpeter	ocument whether the resonantly was assessed and encies and/or other approximates and/or other approximates and the requirements set ion. provided or arranged by comprehensive care plantly and trauma-informed. The provided of the trauma and trauma and trauma and trauma and trauma are the trauma and trauma a	any opriate , as t forth	F 0656	the careplan to reflect the up by 7/7/2023. 6. Education and audits w reviewed at the quarterly Qu Assurance and Performance Improvement meetings.	ill be	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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F 0656	Continued from page 3		F 0656				
SS=E	Based on a review of farecords, and staff interest the facility failed to desplans to meet resident of Residents (Resident Residents (Resident Residents (Resident Residents (Resident Residents (Resident Residents (Resident Residents)). The facility plan Completion date facility will develop a deach resident, and that Assessment Area (CAA facilitate care plan decident Review of the clinical was admitted to the facility was admitted to the facility will develop a decident facilitate care plan decident decident facilitate care plan decident facilitate faci	views, it was determined velop comprehensive care needs for four of p. R35, R148 and R2 coolicy "Comprehens d 8/31/22, indicated comprehensive planeach triggered Care A) must be assessed asion making. The cord indicated Respirity on 12/9/11. The Data Set (MDS - dds) dated 6/5/23, increasing conferences a conference and comprehensive planeach triggered Care A) must be assessed asion making.	ined that e care of 16 246). ive Care the of care for to sident R9 periodic cluded ental				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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F 0656	Continued from page 4			F 0656			
SS=E	symptoms), bipolar dismarked by alternating plepression), and post-treating plepression), and post-treating or witness. Review of Resident R9 2/21/23, did not identified diagnosis, symptoms of diagnosis and resident the resident's needs for re-traumatization. Review of the clinical reward was admitted to the factor of the MDS day diagnoses of pneumonic lungs from an infection the lining of the tubes the lungs), and respiratory where the lungs cannot blood).	periods of elation and raumatic stress disordendition triggered by sing a terrifying events are plan, updated by Resident R9's PTS or triggers related to the specific intervention minimizing triggers record indicated Residity on 5/27/23. Ited 6/8/23, indicated a (severe inflammatical), bronchitis (inflammatical), bronchitis (inflammatical) are considered as serious conse	d rder by nt. d SD this as to meet and/or sident R35				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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F 0656	Continued from page 5			F 0656			
SS=E							
	Observation and interv	riew of Resident R35	5 on				
	6/14/23, revealed the re	esident was receivin	g oxygen				
	at three liters per minur		`				
	oxygen delivery device		•				
	tube which on one end are placed in the nostri		gs which				
	Review of Resident R3	35's care plan last rev	viewed				
	5/30/23, failed to inclu	de a plan of care rela	ated to				
	the use of oxygen thera	apy.					
	Review of the clinical	record indicated Res	sident				
	R148 was admitted to t	the facility on 6/9/23	3.				
	Review of the MDS da	ia (severe inflammat	ion of the				
	lungs from an infection), respiratory failur condition where the lungs cannot get enou		`				
	into the blood), and dep						
	oxygen.	. 11					
	Review of physician's	orders indicated curr	rent				

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER		₹:		IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
395164		395164		A. BLDG: _ B. WING: _	00	06/16/2023	
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			STREET ADDRESS, P O BOX 928 MARS, PA 16	500 WITTE	CIP CODE: SNBERG WAY		
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F 0656	Continued from page 6			F 0656			
SS=E	orders to titrate oxygen saturation (the amount blood) above 90%. Observation and interv 6/12/23, revealed the reat 3 liters per minute visual 3 liters per minute visual 4 liters per minute visual 5/12/23, failed to inclust the use of oxygen there. During an interview or Director of Nursing (Director	iew of Resident R14 esident was receiving in a nasal cannula. 48's care plan last rede a plan of care related a plan of care related to the care plans. 6/16/23, at 11:03 at ON) confirmed the rehensive care plans. Residents R35 and I are the facility on 6/7/23 at ted 6/15/23, indicated that Resident farction (necrotic times and farction (necrotic times are the facility on 6/7/23).	at the set on the set				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		395164			<u></u>	06/16/2023	
ST. JOHN	VIDER OR SUPPLIER: SPECIALTY CARE CTR E NUMBER: 970802		P O BOX 928 MARS, PA 16	500 WITTE	IP CODE: NBERG WAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0656	Continued from page 7			F 0656			
SS=E	brain), hypertension (harteries), and dysphagian Review of physician on that Resident R246 is the by mouth). Review of Resident R2 revealed interventions preferences, monitoring and providing necessary between meals. During an interview of DON confirmed that the comprehensive care planeds of four of 16 residents. 28 Pa. Code: 211.11(a) plan.	a (difficulty swallow rder dated 6/7/23, rego be NPO (receive noted that included honoring oral intake of food ry assistance at mealing a 6/16/23, at 12:02 page facility failed to dean to meet resident contents.	vealed tothing lan ng food and fluid, time and .m. the evelop a care				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:		
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F 0695 SS=E	483.25(i) Respiratory/Trach § 483.25(i) Respiratory care and tracheal suctioning. The facility must ensure tha respiratory care, including t suctioning, is provided such professional standards of pr person-centered care plan, t preferences, and 483.65 of t This REQUIREMENT is no	e, including tracheostom t a resident who needs racheostomy care and tractice, consistent with actice, the comprehensive he residents' goals and this subpart.	y care acheal	F 0695	1. Resident R35 has an up order for oxygen and oxyger changes. The oxygen tubing equipment for R148. An ordoxygen tubing and nebulizer equipment changes every 2 v was added for residents R143 was discharged on 6/21/23. 2. Nurses notes will be me each business day during clir report. Any residents with ne respiratory diagnoses or treat will be discussed and orders reviewed to ensure equipment changes are entered beginnin 6/28/23 and will continue on 3. Residents who receive of the the theory or respiratory care witheir orders audited by 7/14/2 ensure orders for equipment changes are entered. Resident equipment will be audited w x4 weeks then biweekly ong ensure that they are being stoproperly and changed timely 4. DON or designee will enursing staff on proper storation oxygen equipment by 7/14/25. Education and audits w reviewed at the quarterly Qu Assurance and Performance Improvement meetings	atubing and er for weeks 8. R152 onitored nical ew timents on the early for oing to ored ducate ge of 3. ill be	Completion Date: 07/28/2023 Status: APPROVED Date: 07/10/2023

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	R:			(X3) DATE SURVEY COMPLETED:	
	395164			A. BLDG:00 B. WING:		06/16/2023	
ST. JOHN	VIDER OR SUPPLIER: SPECIALTY CARE CTR E NUMBER: 970802		STREET ADDRESS, P O BOX 928 MARS, PA 10	500 WITTE	MP CODE: SNBERG WAY		
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F 0695	Continued from page 9			F 0695			
SS=E							
	Based on review of fac	eility policies, residen	nt				
	observations and interv	•	*				
	and staff interviews, it facility failed to provid						
	for three of five resider		-				
	and R152).	,	,				
	Findings include:						
	Review of the facility's	s policy "Oxygen Vi	a				
	Concentrator" dated 8/						
	facility will verify phys						
	therapy and that oxyge every 2 weeks and as n	~	ngea				
	Review of the clinical was admitted to the fac	sident R35					
	Review of the Minimu assessment of care need	ds) dated 6/8/23, ind	licated				
	diagnoses of pneumoni lungs from an infection	`					
	rungs nom an infection	i), oronemus (iiiiaii	iiiiatioii 01				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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ST. JOHN	VIDER OR SUPPLIER: SPECIALTY CARE CTR SE NUMBER: 970802		STREET ADDRESS, P O BOX 928 MARS, PA 16	500 WITTE	CIP CODE: CNBERG WAY		
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F 0695	Continued from page 10			F 0695			
SS=E	the lining of the tubes the lungs), and respiratory where the lungs cannot blood). Observation and interve 6/14/23, at 11:09 a.m. and receiving oxygen at 3 has a cannula (an oxygen dellightweight tube which prongs which are placed. Review of the clinical and current physician order oxygen therapy and a coxygen tubing per facil. During an interview on Assistant Director of Not there was no order for to change oxygen tubing. Review of the facility's service of the facility service of the facilit	failure (a serious co get enough oxygen iew of Resident R35 revealed the resident iters per minute via ivery device consist on one end splits in d in the nostrils). record failed to rever for Resident R35 to turrent order to chan ity policy.	ndition into the on was a nasal ing of a to two al a receive ge m. the firmed no order				

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
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F 0695	Continued from page 11			F 0695			
SS=E	Nebulizer Administration the facility will discommand medication cup who complete, store the equather resident 's name are equipment and tubing process. Review of the clinical R148 was admitted to a Review of the MDS dadiagnoses of pneumonal lungs from an infection condition where the luninto the blood), and depoxygen. Review of physician's indicated a current ordinal maintain oxygen saturation present in the blood) and depoxygen and the blood of the process of the	nect the T-piece, monen the nebulizer treatipment in a plastic build the date on it, and per facility policy. The record indicated Rest the facility on 6/9/23 atted 6/12/23, indicated in (severe inflammated), respiratory failured from the facility on supplementation of the amount of attention (the amount of the amount of	uthpiece, atment is bag with change sident 3. ed cion of the e (a serious gh oxygen mental				
	Review of physician's	orders dated 6/9/23,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER 395164			' '	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 06/16/2023				
ST. JOHN	VIDER OR SUPPLIER: SPECIALTY CARE CTR SE NUMBER: 970802		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 928 500 WITTENBERG WAY MARS, PA 16046						
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE		
F 0695	Continued from page 12		F 0695						
SS=E	indicated a current ord nebulizer solution (and treat and prevent symptof breath, and difficult.) Observation and intervent 6/13/23, at 10:13 a.m. receiving oxygen there a nasal cannula and the medication cup assemble machine while not in undervalidation and intervent 6/14/23, at 10:32 a.m.	hortness es daily. 8 on twas nute via a as on the e, and op of the							
	receiving oxygen thera nasal cannula and the r bedside table with the medication cup assemb machine while not in u Review of the clinical current order to change	nebulizer machine w T-piece, mouthpiece bled and sitting on to se.	as on the , and op of the						

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	A. BLDG:	00	(X3) DATE SURVEY COMPLETED:				
	B. WING:		06/16/2023				
P O BOX 92	STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 928 500 WITTENBERG WAY MARS, PA 16046						
ES (EACH DEFICIENCY ULATORY OR LSC TION)	ID PREFIX TAG	CORRECTIVE ACTION SE	HOULD BE	(X5) COMPLETE DATE			
	F 0695						
E12:28 p.m. E1 confirmed the d not stored per hen asked how he oxygen tubing ee E1 stated, rofile to change sion nurse enters of the admission E10:55 a.m. the der to change nge nebulizer policy. Eated Resident on 6/3/23. Indicated resident per heart							
	ES (EACH DEFICIENCY ULATORY OR LSC TION) E 12:28 p.m. E1 confirmed the d not stored per hen asked how he oxygen tubing ee E1 stated, rofile to change sion nurse enters of the admission E 10:55 a.m. the der to change nge nebulizer policy. Eated Resident on 6/3/23.	STREET ADDRESS, CITY, STATE, ZIPOBOX 928 500 WITTE MARS, PA 16046 ES (EACH DEFICIENCY ULATORY OR LSC TION) F 0695 F 0695 F 0695 F 0695 A 12:28 p.m. E1 confirmed the donot stored per then asked how the oxygen tubing the experimental energy of the admission E 10:55 a.m. the der to change the admission E 10:55 a.m. the der to change the negative policy. Exact Resident to 6/3/23. Exact Resident to 6/3/23.	STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 928 500 WITTENBERG WAY MARS, PA 16046 ES (EACH DEFICIENCY ULATORY OR LSC TION) F 0695 F 0695 F 0695 12:28 p.m. E1 confirmed the d not stored per then asked how the oxygen tubing the ee E1 stated, rofile to change sion nurse enters In the admission 10:55 a.m. the der to change nge nebulizer policy. 10:410:55 a.m. the der to change nge nebulizer policy. 10:410:410:410:410:410:410:410:410:410:4	STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 928 500 WITTENBERG WAY MARS, PA 16046 ES (EACH DEFICIENCY ULATORY OR LSC TION) F 0695 F 0695 F 0695 F 12:28 p.m. E1 confirmed the d not stored per then asked how the oxygen tubing the eE I stated, rofile to change sion nurse enters of the admission f 10:55 a.m. the der to change nge nebulizer poolicy. tated Resident on 6/3/23. , indicated			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	BER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0695	Continued from page 14			F 0695				
SS=E	disease that affects pur muscles), diabetes (a n the body has high suga of time), and dependent Review of physician's indicated current order oxygen saturation >90. Review of physician's indicated current order that is inhaled to make the muscles in the lung inhalation every six how Review of physician's indicated current order solution (an inhaled may prevent symptoms of vand difficulty breathing days for shortness of by Observation and intervent	netabolic disorder in r levels for prolonge ace on supplemental orders dated 6/9/23, s to titrate oxygen to 2/6. orders dated 6/3/23, s for Albuterol (a mobreathing easier by s and widening the aurs as needed for whorders dated 6/14/23 s for DuoNeb inhala edication used to treather the supplemental orders dated for whorders dated 6/14/23 s for DuoNeb inhala edication used to treather the supplemental orders dated for whorders dated for whorders dated for whorders dated for used in the supplemental orders dated for whorders dated for used in the supplemental orders dated for whorders dated for whorders dated for used in the supplemental orders dated for whorders dated for used in the supplemental orders dated for whorders dated for whorders dated for used in the supplemental orders dated for whorders dated for whorders dated for used in the supplemental orders dated for whorders dated for whorders dated for used in the supplemental orders dated for whorders dated for used for the supplemental orders dated for whorders dated for used for the supplemental orders dated for whorders dated for used for used for the supplemental orders dated for used f	which ed periods oxygen. maintain edication relaxing airway) neezing. tion at and of breath, or three					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:		
		395164		B. WING:		06/16/2023		
ST. JOHN	VIDER OR SUPPLIER: SPECIALTY CARE CTR SE NUMBER: 970802		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 928 500 WITTENBERG WAY MARS, PA 16046					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE		
F 0695	Continued from page 15			F 0695				
SS=E	6/12/23, at 11:29 a.m. receiving oxygen thera nasal cannula. Observation and interv 6/15/23, at 12:24 p.m. receiving oxygen thera nasal cannula and the month bedside table wi and medication cup ass the machine while not receive of the clinical recurrent order to change nebulizer equipment are During an interview on Employee E1 confirme assembled and not storn not in use. During an interview on ADON confirmed there	py at 3 liters per minimise of Resident R15 revealed the resident py at 3 liters per minimise bulizer machine with the T-piece, mout sembled and sitting of in use. The example of the oxygen tubing and tubing. The following of the nebulizer set used per facility policy at 6/16/23, at 11:03 a.	nute via a 52 on t was nute via a as sitting thpiece, on top of al a and the .m. RN up was y while					

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED:			
		395164			<u></u>	06/16/2023			
ST. JOHN	VIDER OR SUPPLIER: SPECIALTY CARE CTR E NUMBER: 970802		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 928 500 WITTENBERG WAY MARS, PA 16046						
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE			
F 0695	Continued from page 16			F 0695					
SS=E	oxygen tubing and no cequipment and tubing page 28 Pa. Code: 201.14(a) 28 Pa. Code 211.12(d) 28 Pa. Code: 211.12(d)	per facility policy. Responsibility of l (1)(2)(5) Nursing set	icensee. rvices						
F 0812				F 0812					
SS=F									

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395164			00	06/16/2023	
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802		P O BOX 928 MARS, PA 10	500 WITTE	IIP CODE: NBERG WAY			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0812	Continued from page 17			F 0812			
SS=F	483.60(i)(1)(2) Food Procurement,Store/Prepare/ §483.60(i) Food safety requ The facility must - §483.60(i)(1) - Procure food considered satisfactory by for authorities. (i) This may include food ite producers, subject to applicate regulations. (ii) This provision does not from using produce grown i compliance with applicable practices. (iii) This provision does not consuming foods not procur §483.60(i)(2) - Store, prepart accordance with professional safety. This REQUIREMENT is not	irements. If from sources approved ederal, state or local ems obtained directly from the able State and local laws prohibit or prevent facil in facility gardens, subject safe growing and food-laws preclude residents from the dot by the facility. The distribute and serve fall standards for food server.	om local s or ities ct to handling		1. All food in the kitchen slabeled and dated on 6/12/20 food that was not labeled and in the refrigerator on the unit discarded on 6/16/2023. All food was discarded on 6/16/2023. All food was discarded on 6/16/2 Food stored under the sink we discarded. A temperature log placed at the refrigerator on will ensure that all refrigerate freezers have temperature log them by 7/7/2023. Dietary Dipurchased test strips and the received on 7/12/2023 from 3. Dietary Director of designed dating of foods stored by 7/14/2023. Dietary of designee will educate food employees on the procedure using test strips by 7/21/2022. Director of Nursing or designed date staff on documenting refrigerator and freezer temp 4. Dietary Director or designed audit food storage twice week beginning 7/1/2023. Dietary of designee will audit the use	d dated t was expired 2023. Vas g was the unit. designee ors and gs on birector y were ecolab. ignee will oper being Director d service for 3. nee will g bs. ignee will g bs. ignee will ckly Director	Completion Date: 07/28/2023 Status: APPROVED Date: 07/13/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
		395164		B. WING:		06/16/2023	
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			STREET ADDRESS, P O BOX 928 MARS, PA 16	500 WITTE	IP CODE: NBERG WAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0812 SS=F	Continued from page 18			F 0812	test strips on a daily basis be 7/11/2023. Director of Nursi designee will audit refrigerat and food stored on the unit for proper storage and expiration weekly for 4 weeks and then until substantial compliance obtained. 5. Education and audits w reviewed at the quarterly Qu Assurance and Performance Improvement meetings	ng or tor logs or ns monthly is	

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395164		B. WING:	<u></u>	06/16/2023	
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			P O BOX 928 MARS, PA 16	500 WITTE	IIP CODE: NBERG WAY	•	
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0812	Continued from page 19			F 0812			
SS=F	Based on a review of facility policies, observand staff interviews it was determined that the failed to properly label and date food productiverify the sanitizing temperature of the dishin the Main Kitchen (Main Kitchen), and promonitor refrigerator temperatures, and properstore food products in one of three nursing upantries (Brookfield) and failed to properly food and monitor food for expiration dates in of three nursing unit pantries (Brookfield, Wand Creekside), which created the potential faborne illness. Findings Include: Review of the facility policy "Food Storage: Sanitation and Infection Control" last review 3/23/23, indicated that all products are labeled dated with the receiving date. Review of the facility policy "Dishwashing a Washing Procedures: Sanitation and Infection Control" last reviewed 3/23/23, indicated that Teviewed 3/23/23, indicated that Procedures: Sanitation and Infection Control" last reviewed 3/23/23, indicated that Procedures: Sanitation and Infection Control" last reviewed 3/23/23, indicated that Procedures: Sanitation and Infection Control" last reviewed 3/23/23, indicated that Procedures: Sanitation and Infection Control" last reviewed 3/23/23, indicated that Procedures: Sanitation and Infection Control" last reviewed 3/23/23, indicated that Procedures: Sanitation and Infection Control" last reviewed 3/23/23, indicated that Procedures: Sanitation and Infection Control" last reviewed 3/23/23, indicated that Procedures: Sanitation and Infection Control Procedures: Sanitation and Infection Con		the facility acts, and a machine roperly berly unit date in three Wellstep, I for food e: e: ewed eled and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER 395164			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00_ B. WING:		(X3) DATE SURVEY COMPLETED: 06/16/2023		
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			STREET ADDRESS, P O BOX 928 MARS, PA 16	500 WITTE	IP CODE: INBERG WAY	l	
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0812 SS=F	setting the right temper dishwasher is critical to cookware, dishes, and illness. Dishwasher temanufacturer's guidelinationally recognized smachine temperatures before use for each me Review of the facility Resident's Room from reviewed 3/23/23, indibrought in from outsideresident's name and redate the food with the community for sthe original container the expiration date will be Nursing staff will mon pantry, and refrigerated disposal. All refrigerate thermometers to monitimust be maintained at	tensure property satutensils to prevent for imperatures are main the sand in accordance standards of practice are checked and recordance al cleanup period. Dolicy "Food Brough Outside Sources" lacated that foods or be will be labeled with foom number. Nursing date the item(s) was torage. Food or bever hat is past the manufactor resident's room, on units for food and tion units will have it or temperatures. Al	nitized bodborne tained per te with Dish borded at into st everages h the ng will brought erage in facturer's g staff. household beverage internal l units	F 0812			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: (X3) DATE SURV COMPLETED:		(X3) DATE SURVE COMPLETED:	EY	
		395164				06/16/2023	
ST. JOHN	VIDER OR SUPPLIER: SPECIALTY CARE CTR E NUMBER: 970802		P O BOX 928 MARS, PA 16	500 WITTE	IP CODE: NBERG WAY		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0812	Continued from page 21			F 0812			
SS=F	deemed safe for food s During an observation refrigerator, on 6/12/23 wrapped package of melabel or date. During an interview with Employee E2 confirmed properly label and date During an observation room, on 6/13/23, at 1: the facility does not verof the dish machine by strip through the dish melabel condition of the dish melabel c	in the Main Kitchen 8, at 9:55 a.m., a plase eat was observed with the Food Service ed that the facility fare food products. in the Main Kitchen 15 p.m. it was revearify the final rinse te running a temperaturachine to verify the fachine. 16/13/23, at 1:32 p.m. Employee E2 confirmate certain the final machine was operaturachine was operaturachine was operaturated.	Director iled to dish led that emperature are test e operating m., the emed that				

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIEF PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			A. BLDG: _	(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED:			
		395164		B. WING: _		06/16/2023			
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 928 500 WITTENBERG WAY MARS, PA 16046						
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE			
F 0812 SS=F	During an observation Unit Pantry on 6/16/23 was noted: -The small refrigerator of salad with no dateRefrigerator temperator refrigerator was absent -A case of applesauce sinkBaskets of prepackage without datesThree packages of Fig past the manufacture 's During an interview or Clinical Manager Regi and the Director of Nu the facility failed to pre record refrigerator tem food, and failed to disp products.	to contained a plastic of the small of the s	container th the d nd to be 6/12/23. .m., yee E3, ned that onitor and store	F 0812					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		LIA	A. BLDG: _	PLE CONSTRUCTION: 00	(X3) DATE SURVI COMPLETED:	ΞY	
		395164		B. WING:		06/16/2023	
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			P O BOX 928 MARS, PA 16	500 WITTE	IP CODE: NBERG WAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0812	Continued from page 23			F 0812			
SS=F	During an observation Pantry on 6/16/23, at 1 noted: -Baskets of prepackage without datesFour packages of sugate past the manufacture 6/1/23. During an interview on DON confirmed that the date food and dispose of During an observation Unit Pantry on 6/16/23 was noted: -Baskets of prepackage without datesSix packages of sugar be past the manufacture 6/1/23, and 6/15/23.	o:30 a.m., the followed snacks were stored at free cookies were e's expiration date of 6/16/23, at 10:42 a. The facility failed to profer food produce on the Creekside Nu, at 10:50 a.m., the first snacks were stored free cookies were for	d found to of m., the roperly ucts. ursing following				

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		* *	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395164			B. WING: 06/16/2023			
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			P O BOX 928 : MARS, PA 16	500 WITTE	MP CODE: NBERG WAY			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEI ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
F 0812 SS=F	Continued from page 24			F 0812				
	During an interview on 6/16/23, at 10:54 a.m., the DON confirmed that the facility failed to properly date food and dispose of expired food products. 28 Pa. Code: 211.6 (c)(d)(f) Dietary Services.							
F 0943				F 0943				
SS=D								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER:SUPPLIER/ IDENTIFICATION NUMBER				PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
395164		395164			06/16/2023		
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			STREET ADDRESS, P O BOX 928 MARS, PA 16	500 WITTE	MP CODE: NBERG WAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0943 SS=D	Continued from page 25 483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:		est also locates ect, exty as abuse, ident	F 0943	1. Employees E4 and E5 v complete all required training 7/14/2023. 2. Staff education is assign monthly to all staff to meet to trainings required for their postaff educator or designee w trainings monthly to ensure to completion. 3. The Clinical Educator of designee will audit employed records. Staff out of complia education requirements will required to complete the trainlater than 7/14/2023 or will be removed from the schedule wompleted. 4. Administrator or design educate managers on the important of monitoring staff education 7/7/2023. 5. Education and audits we reviewed at the quarterly Quentile Assurance and Performance Improvement meetings	gs by ned he ositions. ill audit timely or e training nce with be nings no be antil nee will bortance n by ill be	Completion Date: 07/28/2023 Status: APPROVED Date: 07/11/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	I) PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
	395164			B. WING:		06/16/2023		
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 928 500 WITTENBERG WAY MARS, PA 16046					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE		
F 0943	Continued from page 26			F 0943				
SS=D								
	Based on review of fac	ility policy and docu	uments,					
	and staff interview, it v		-					
	failed to provide training	-						
	prevention for two of to E4 and E5).	mpioyees						
	Findings include:							
	Review of the "Facility	Assessment" dated	9/28/22,					
	indicated facility staff	-	1					
	mandatory training on misappropriation, and o							
	The facility "Abuse, Pr Mental Abuse, Reports	_						
	Misappropriation of Pr							
	8/31/22, indicated all e							
	participate in mandator							
	to resident rights and tr	raining relating to ab	ouse.					
	Review of Nurse Aide education record indica							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER			` ´	PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	EΥ	
395164				<u></u>	06/16/2023		
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			STREET ADDRESS, P O BOX 928 MARS, PA 16	500 WITTE	IP CODE: NBERG WAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0943	Continued from page 27			F 0943			
SS=D	Review of NA Employee E4's training record for 1/7/22, through 1/7/23, did not include training on abuse and neglect. Review of Registered Nurse (RN) Employee E5's education record indicated she was hired on 2/26/19. Review of RN Employee E5's training record for 2/26/22, through 2/26/23, did not include training on abuse and neglect. During an interview on 6/14/23, at 2:37 p.m. the Nursing Home Administrator confirmed that the facility failed to provide documentation of training for abuse and neglect prevention for two of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management.						

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED:	
395164		395164			<u> </u>	06/16/2023	
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802		STREET ADDRESS, P O BOX 928 : MARS, PA 16	500 WITTE	MP CODE: NBERG WAY			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0949 SS=B	\$483.95(i) Behavioral Health Training §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by:			F 0949	1. Employees E4 and E5 v complete all required training 7/14/2023. 2. Staff education is assign monthly to all staff to meet t trainings required for their postaff educator or designee w trainings monthly to ensure t completion. 3. The Clinical Educator or designee will audit employed records. Staff out of complia education requirements will required to complete the train later than 7/14/2023 or will be removed from the schedule w completed. 4. Administrator or design educate managers on the important of monitoring staff education 7/7/2023. 5. Education and audits w reviewed at the quarterly Que Assurance and Performance Improvement meetings	gs by ned he ositions. ill audit timely or e training nce with be nings no be antil nee will bortance n by ill be	Completion Date: 07/28/2023 Status: APPROVED Date: 07/11/2023

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
395164			B. WING:		06/16/2023		
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			STREET ADDRESS P O BOX 928 MARS, PA 10	500 WITTE	MP CODE: NBERG WAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0949	Continued from page 29			F 0949			
SS=B							
	Based on review of fac	cility policy and docu	uments,				
	and staff interview, it v		-				
	failed to provide training	•					
	dementia for two of ter E4 and E5).	n staff members (Em	ipioyeees				
	Findings include:						
	Review of the "Facility	Assessment" dated	9/28/22,				
	indicated all nursing st	aff will have training	g on				
	Alzheimer's/Dementia/	Cognitive Impairme	ents.				
	Review of Nurse Aide	(NA) Employee E4'	s				
	education record indica	ated she was hired or	n 1/7/16.				
	Review of NA Employ	-					
	1/7/22, through 1/7/23, did not include tra						
	behavioral health and o	dementia.					
	Review of Registered 1	ee E5's					
	education record indica						
	2/26/19. Review of RN		_				
	record for 2/26/22, thro	t include					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395164			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 06/16/2023	ΞY	
NAME OF PROVIDER OR SUPPLIER: ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802			P O BOX 928 : MARS, PA 16	500 WITTE	IIP CODE: NBERG WAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0949	Continued from page 30			F 0949			
SS=B	training on behavioral health and dementia. During an interview on 6/14/23, at 2:37 p.m. the Nursing Home Administrator confirmed that the facility failed to provide documentation of training on behavioral health and dementia for two of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.						

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Certified End Page

ST. JOHN SPECIALTY CARE CTR

STATE LICENSE NUMBER: 970802 SURVEY EXIT DATE: 06/16/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY